DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization Amendment Request to the Prior Authorization Request Form (PA/RF) and physician's orders (within 90 days of the dated signature) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Today's Date
Enter today's date in MM/DD/YYYY format.

Element 2 — Previous PA Number
Enter the seven-digit PA request number from the PA/RF to be amended. The request number is located in the top right section of the PA/RF.

Element 3 — Name — Recipient
Enter the recipient's name as indicated in Element 8 on the PA/RF, including recipient's last and first name and middle initial.

Element 4 — Recipient Medicaid Identification No.
Enter the ten-digit recipient Medicaid identification number as indicated in Element 5 on the PA/RF.

SECTION II — PROVIDER INFORMATION

Element 5 — Name — Billing Provider
Enter the billing provider's name as indicated in Element 1 of the PA/RF.

Element 6 — Billing Provider's Medicaid Provider No.
Enter the eight-digit billing provider's Medicaid provider number as indicated in Element 4 on the PA/RF.

Element 7 — Address — Billing Provider
Enter the billing provider's address (include street, city, state, and Zip code) as indicated in Element 1 of the PA/RF.

Element 8 — Amendment Effective Dates
Enter the dates that the requested amendment should start and end.

SECTION III — AMENDMENT INFORMATION

Element 9
Enter the reasons for requesting additional service(s) for the recipient.

Element 10
Enter the appropriate procedure code and hours per day, days per week, multiplied by the number of weeks for each service.

Element 11 — Signature — Requesting Provider
Enter the signature of the provider requesting this amendment.

Element 12 — Date Signed
Enter the month, day, and year this amendment was signed (in MM/DD/YYYY format).